STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING _____ B. WING 00	11/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAVEN CARE & REHABILITATION CENTER	1201 DALY DR NEW HAVEN, IN 46774

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F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00118506. Complaint IN00118506 - Unsubstantiated, due to lack of evidence. Survey dates: October 29, 30 & 31 and November 1 & 2, 2012 Facility number: 000114 Provider number: 155207 AIM number: 100266640 Survey team: Angela Strass, RN TC Sue Brooker, RD Rick Blain, RN Diane Nilson, RN (October 29, 30 & 31 and November 1, 2012) Census bed type: SNF/NF: 90 Total: 90 Census payor type: Medicare: 7 Medicaid: 64 Other: 19 Total: 90	F0000	This plan of correction is prepared and executed because it is required by the provisions of the state and federal law and not because New Haven Care and Rehabilitation agrees with the allegations and citations listed on pages 1 through 13 of this statement of deficiencies. New Haven Care and Rehabilitation maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to constitute substandard quality of care or limit our capability to render adequate care. Please accept this plan of correction as our credible allegation of compliance.New Haven Care and Rehabilitation is also requesting Desk Review, Paper Compliance for the alleged deficiencies from our recent annual survey.F279 F315 F371 F441November 16, 2012Brenda MeredithPublic Health Nurse SupervisorDivision of Long Term Care2 North Meredian StreetIndianapolis, IN 46204Request for Desk Review of the following Deficiencies listed on our recent 2567 following annual survey for the facility.Dear Brenda: Thank you for taking the time to review the recently submitted 2567, from New Haven Care and Rehabilitation Center, New Haven, Indiana. I am	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 11/08/12 by Suzanne Williams, RN		requesting desk review compliance as I feel that the citations were isolated events, with corrections immediately taken to correct those deficiencies. I do not believe that any residents' were harmed by the deficiencies, validating my request for a desk review.Staff was in serviced, and re-educated related to infection control processes by the ADNS 11/10/2012 through 11/15/2012, on proper handling and distribution of clean linens as well as proper placement of coverings for any resident's who utilize a catheter within the facility to decrease the potential for the spread of possible infection, also promoting cleanliness and proper care of handling and securing catheter tubing. The facility takes pride in the fact that we represented very well during the survey process, and continue to be compliant in all other areas.An auditing control system was put into place for review of the deficiencies listed in the 2567 to identify areas potentially at risk for these types of findings. (Infection control related to handling of linens, catheter tubing care, dietary storage and handwashing). Areas addressed by the POC will continue to be monitored for a period of no less than 6 months so that the facility can ensure that best practices with a focus on infection control and storage of dried goods in the	

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			dietary department.I am pleased to announce that we have maintained an excellent record in all areas and provide the highest quality of care. This is evidenced by our yearly reviews, with very low percentage of complaints related to our facility over the last few years. I would greatly appreciate your consideration into our request for desk review of this 2567. Respectfully Submitted: Kris Schmitt R.N. / D. N. SNew Haven Care and Rehabilitation	

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a care plan to address behaviors for 1 resident (Resident #69) of 45 residents reviewed for care plans. Findings include: The record for Resident #69 was reviewed on 10/30/12 at 1:00 P.M. Diagnoses included, but were not limited to, depressive disorder and generalized anxiety disorder. A Social Service Progress note dated	F0279	This plan of correction is prepared and executed because it is required by the provisions of the state and federal law and not because New Haven Care and Rehabilitation agrees with the allegations and citations listed on pages 1 through 13 of this statement of deficiencies. New Haven Care and Rehabilitation maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to constitute substandard quality of care or limit our capability to render adequate care. Please accept this plan of	11/16/2012

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	9/5/12 indicated "...resident was yelling out and swearing." The note indicated the resident "...became even more irate, screaming out, and kicking...." A Social Service note dated 10/12/12 indicated "Resident conts (continues) to yell at staff during the day about random topics." The note further indicated "Resident is very difficult to redirect, and will often become irate." A progress note from the psychologist, dated 10/8/12, indicated "Staff reports that patient becomes upset easily. His mood varies from day to day. Patient has been verbally and physically abusive towards staff. Patient has kicked staff." Recommendations from the psychologist indicated "Staff should respond to patient in a non-threatening manner and attempt to intervene before patient becomes aggressive. Encourage patient to be patient with others. Staff may want to offer praise and reward for any acts of self control. Assess patient for pain, discomfort, or other reasons for agitation." There was no care plan in Resident #69's record addressing behaviors or mood.		correction as our credible allegation of compliance.New Haven Care and Rehabilitation is also requesting Desk Review, Paper Compliance for the alleged deficiencies from our recent annual survey.F279 F315 F371 F441November 16, 2012Brenda MeredithPublic Health Nurse SupervisorDivision of Long Term Care2 North Meredian StreetIndianapolis, IN 46204Request for Desk Review of the following Deficiencies listed on our recent 2567 following annual survey for the facility.Dear Brenda: Thank you for taking the time to review the recently submitted 2567, from New Haven Care and Rehabilitation Center, New Haven, Indiana. I am requesting desk review compliance as I feel that the citations were isolated events, with corrections immediately taken to correct those deficiencies. I do not believe that any residents' were harmed by the deficiencies, validating my request for a desk review.Staff was in serviced, and re-educated related to infection control processes by the ADNS 11/10/2012 through 11/15/2012, on proper handling and distribution of clean linens as well as proper placement of coverings for any resident's who utilize a catheter within the facility to decrease the potential for the spread of possible infection, also	

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	The facility Social Service Director (SSD) was interviewed on 10/31/12 at 9:00 A.M. During the interview, the SSD indicated Resident #69 sometimes displayed anger, agitation, and verbal and physical aggression. A Behavior Monthly Flow Sheet for Resident #69 was provided by the SSD and indicated the resident was being monitored for "depressed withdrawn", "agitated", and "angry". The SSD indicated a care plan addressing Resident #69's behaviors and mood had not been developed. The SSD did indicate the facility "Behavior Blue Slips", which were used by staff to report behaviors, did list general interventions to be used for all residents, but a care plan with specific behavioral interventions and goals should have been developed for Resident #69, including the interventions recommended by the psychologist. A policy on care plans, dated 1/08, was provided by the facility nurse consultant on 10/31/12 at 9:50 A.M. The policy indicated "The Interdisciplinary Team (IDT) develop care plans within 24 hours of admission addressing the resident's most acute problems. The care plan is comprehensive for each resident including measurable objectives and		promoting cleanliness and proper care of handling and securing catheter tubing. The facility takes pride in the fact that we represented very well during the survey process, and continue to be compliant in all other areas.An auditing control system was put into place for review of the deficiencies listed in the 2567 to identify areas potentially at risk for these types of findings. (Infection control related to handling of linens, catheter tubing care, dietary storage and handwashing). Areas addressed by the POC will continue to be monitored for a period of no less than 6 months so that the facility can ensure that best practices with a focus on infection control and storage of dried goods in the dietary department.I am pleased to announce that we have maintained an excellent record in all areas and provide the highest quality of care. This is evidenced by our yearly reviews, with very low percentage of complaints related to our facility over the last few years. I would greatly appreciate your consideration into our request for desk review of this 2567. Respectfully Submitted: Kris Schmitt R.N. / D. N. SNew Haven Care and RehabilitationPlease see the attached plan of correction for survey conducted at New Haven Care and Rehabilitation Center on 10/29/2012. New Haven Care and Rehab would respectfully	

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	timetables to meet resident's medical, nursing, and mental and psychosocial needs." 3.1-35(a)		request paper compliance on this plan of correction. These interventions were put into place immediately following the investigation with all department head staff fully in-serviced by 11-1-12. Implementations will be presented in the November, 2012 QA meeting and continue as a permanent agenda item. F 279 SS=D **1. How will the facility identify other residents having the potential to be affected by the same deficient practice?** On 10/30/12 the SS Director completed an audit of the residents residing at the center on psychotropic therapy as ordered by the physician with all comprehensive care plans in place. No other residents were affected.**2. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?3. What Measures will be put into place or what systemic changes you will make to assure the deficient practice does not recur? The Social Service Director and Unit Managers will review new admissions, re-admissions, and new orders for residents on psychotropic medications in the clinical meeting daily to ensure a comprehensive behavioral care plan is completed. 4. How will the facility monitor its corrective actions to ensure**	

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			the deficient practice will not recur? The Social Service Director and Unit Managers will audit residents with psychotropic medications in the weekly CARE meeting to ensure a behavioral comprehensive care plan is completed weekly for 1 month then monthly for 6 months. These audits will be reviewed at the monthly Performance Improvement Committee for any further recommendations. The **Director of Nursing/ Social Service Director will review the audits at the next monthly Performance Committee Meeting for any further recommendations. Audits will be ongoing to ensure compliance with CarePlans.**The Social Service Director completed a comprehensive care plan to include the behaviors for Resident #69 psychotropic medications on 10/30/12. The Social Service Director was re-educated by the Director of Nursing on 10/30/12 to ensure a behavioral comprehensive care plan was in place for residents with psychotropic medications ordered by the physician.	

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to keep catheter tubing off of the floor for 2 of 2 residents (Resident #39 and Resident #8) who were reviewed for catheters of 10 residents who met the criteria for urinary catheter use. Findings include: Review of the clinical record for Resident #39 on 10/31/12 at 2:11 p.m., indicated diagnoses included, but were not limited to, unspecified disorder of kidney and ureter and urinary tract infections. A physician's order for Resident #39, dated for the month of October, 2012, indicated an indwelling catheter, starting on 5/31/12. A physician's order for Resident #39,	F0315	F 315 SS=DA. How will the facility identify other residents having the potential to be affected by the same deficient practice? **a. The Director of Nursing completed an audit with residents residing in the center with utilization of a Foley catheter with no other residents identified to be affected on 11/2/12.B. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?b. Resident #39 and Resident #8 Foley catheter tubing was re-positioned so that it would not touch the floor on 11/2/12. The nursing staff were re-educated by the Assistant Director of Nursing, Unit Managers, and designee on positioning of the proper positioning of tubing for Foley catheters by 11/15/12.C. What Measures will be put into place or what systemic changes you**	11/16/2012

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	dated 7/31/12, indicated Macrobid (antibiotic) 100 mg (milligrams) BID (twice a day) for 10 days d/t (due to) UTI (urinary tract infection). A Urinalysis lab report for Resident #39, dated 7/29/12, indicated 3+ bacteria. A urine culture report, dated 7/29/12, indicated Morganella morganii. A physician's order for Resident #39, dated 8/1/12, indicated Omnicef 300 Cephalosporin (antibiotic) BID for 10 days due to UTI. A Urinalysis lab report for Resident #39, dated 8/14/12, indicated 2+ bacteria. A urine culture report, dated 8/14/12, indicated Escherichia coli. A physician's order for Resident #39, dated 8/16/12, indicated Levaquin (antibiotic) 500 mg (milligrams) per day for 7 days due to UTI. A facility care plan for Resident #39, revised on 9/13/12, indicated the focus area of resident requires catheter related to urinary retention and history of UTI's. Interventions to the focus included, but were not limited to, catheter care q (every) shift and prn (as needed), and observe for sings and symptoms of UTI, such as		**will make to assure the deficient practice does not recur? c. The Assistant Director of Nursing or designee will conduct rounds on residents utilizing a Foley catheter to ensure proper positioning of the Foley catheter tubing to not touch the ground 3 times a week. D. How will the facility monitor its corrective actions to ensure the deficient practice will not recur?** d. The Assistant Director of Nursing or designee will conduct a Foley catheter audit three times weekly times 4 weeks then monthly for 5 months to ensure compliance of catheter tubing not dragging on the floor and that the center ensures compliance. These audits will be reviewed in the monthly Performance Improvement Committee for any further recommendations.The **Director of Nursing/ ADNS/Designee will review the audits at the next monthly Performance Committee Meeting for any further recommendations. Audits will be ongoing to ensure compliance of infection control related to catheter and other tubing that could potentially be an infection control concern.**	

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	increased temperature, foul smelling urine, and decreased output. The care plan did not indicate catheter tubing should not rest on the floor. During an observation of the 300 Hall on 10/31/12 at 10:04 p.m., Resident #39 was observed being pushed in his wheelchair by a visitor from the North activity room to his room. His catheter tubing was observed dragging on the floor. During an observation of the 300 Hall on 10/31/12 at 12:00 p.m., Resident #39 was observed in his wheelchair waiting for his lunch meal. He was observed propelling his wheelchair around the activity room with his feet. His catheter tubing was observed dragging on the floor. During an observation of the Assist Dining Room on 10/31/12 at 8:55 a.m., Resident #39 was observed in his wheelchair eating his breakfast meal. His catheter tubing was observed resting on the floor. During an observation of the Assist Dining Room on 10/31/12 at 9:05 a.m., an un-identified CNA was observed pushing Resident #39 from the assist dining room. His catheter tubing was observed dragging on the			

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	floor. 2. The record for Resident #8 was reviewed on 10/30/12 at 10:00 A.M. Diagnoses included, but were not limited to, neurogenic bladder. On 10/30/12 Resident #8 was continuously observed from 3:00 P.M. until 3:30 P.M. The resident was sitting up in a wheel chair, propelling himself around the room. Tubing from a Foley catheter (indwelling urinary catheter) was observed running from the cuff of his pants into a cloth covered urine collection bag. Approximately ten inches of the tubing was dragging on the floor. At 3:30 P.M. Resident #8 was observed to propel himself from the lounge/activity room and proceed past the nursing desk, down the 400 hall to his room, with the tubing from the catheter dragging on the floor. On 10/31/12, Resident #8 was observed at 8:50 A.M. sitting up in a wheel chair, propelling himself down the 400 hall. Approximately eight inches of the catheter tubing was observed dragging on the floor. On 10/31/12, Resident #8 was continuously observed in the main lounge/activity room from 9:45 A.M.			

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	until 11:15 A.M. The resident was observed sitting up in a wheel chair participating in a group musical activity. Approximately eight inches of tubing from his catheter was observed to be laying on the floor. At 11:15 A.M., the resident was observed to propel himself from the lounge/activity room down the hallway to the main dining room. The tubing from the catheter was observed to be dragging on the floor. On 10/31/12 at 3:00 P.M., Resident #8 was observed propelling himself down the 300 hall in his wheel chair to the North lounge/activity room. Approximately six inches of tubing from the catheter was observed to be dragging on the floor. On 11/1/12 at 2:00 P.M. Resident #8 was observed sitting up in a wheel chair in the North lounge/activity room. Approximately six inches of tubing from the catheter was laying on the floor. LPN #2 was interviewed on 11/2/12 at 9:15 A.M. During the interview, LPN #2 indicated tubing from an indwelling urinary catheter should not be dragging on the floor. On 11/2/12 at 10:30 A.M., the			

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	facility's nurse consultant provided an undated policy on urinary catheters. The policy did not address preventing catheter tubing from being on the floor, but during an interview at that time, the nurse consultant indicated tubing from urinary catheters was not to be laying or dragging on the floor. 3.1-41(a)(2)			

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F0371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food in the dry storage area was stored correctly, and failed to ensure Cook # 3 replaced a soiled steam table well cover with a clean steam table well cover prior to use and washed his hands when indicated, potentially affecting 89 residents who ate meals prepared by the facility kitchen of 90 residents in the facility. Findings include: 1. During the initial tour of the facility kitchen on 10/29/12 at 8:55 a.m., the following was observed in the dry storage room: - a 25 pound bag of instant food thickener was open and not re-sealed; - a 16 ounce bag of potato chips was open and not re-sealed,	F0371	F 371 SS=F**How will the facility identify other residents having the potential to be affected by the same deficient practice? What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The dry food items were placed in sealed containers and stored appropriately on 10/31/12 by the Food Service Director. The floors in the dry storage room were cleaned on 10/31/12 by the Environmental Director. The Cook #3 was re-educated on hand washing technique in the kitchen per the regulatory guidelines. The dietary staff were re-educated on ensuring the floors are clean, dry food items are sealed, and hand washing technique according to regulation by the Food Service Director by 11/15/12.What Measures will be put into place or what systemic changes you will make to assure the deficient practice does not recur? The Food Service Director or designee**	11/16/2012

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	155207	A. BUILDING 00 B. WING	11/02/2012

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	- a 5 pound bag of buttermilk biscuit mix was open and not re-sealed, - the dry storage room floor was dirty, with debris noted on the floor, especially in the corners and under the food storage shelves, and spills which had already dried on dry storage room floor under shelves 2. During the initial tour of the facility kitchen on 10/29/12 at 9:08 a.m., Cook #3, was observed to take a well cover off a lower shelf below the steam table, but it slid on the kitchen floor. He was then observed to pick up the well cover for the steam table from the floor and immediately place in over a steam table well. He then placed other well covers on the steam table. He was not observed to replace the well cover which had slid to the floor and was not observed to wash his hands after picking the well cover off of the floor. 3. During a tour of the facility kitchen on 10/31/12 at 11:35 a.m., the following was observed in the dry storage room: the same 25 pound box of instant food thickener was open and not re-sealed. The Dietary Manager was interviewed on 11/2/12 at 9:00 a.m. During the interview she indicated opened items		**will audit the dietary staff 3 times a week to ensure the kitchen floors are clean, the food in dry storage are sealed, and the dietary staff are washing hands according to regulation to ensure compliance. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? The Food Service Director or designee will audit the dietary staff 3 times a week x 4 weeks, weekly x 8 weeks, then every month for 3 months to ensure the kitchen floors are clean, the food in dry storage are sealed, and the dietary staff are washing hands according to regulation to ensure compliance. These audits will be reviewed at the monthly Performance Improvement Committee for any further recommendations.**The **Director of Nursing/ Dietary Manager or Designee will review the audits at the next monthly Performance Committee Meeting for any further recommendations. Audits will be ongoing to ensure compliance withcleaning schedules, food items being dated, labeled and stored properly. Will also ensure through ongoing review to ensure that no chemical or biological contaminants are**	

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	in the dry storage room should be re-sealed and the floor of the dry storage room floor should be moped every day. She also indicated the cook should have taken the cover for the steam table well that had slid to the floor to the dish machine area to be washed. She further indicated the cook should have washed his hands before placing the other well covers on the steam table. A current facility policy "Food Storage - Dry", with an effective date of 7/08, indicated "...It is the center policy to insure all dry goods will be appropriately stored in accordance with guidelines of the USDA Food Code...." A current facility policy "Food Preparation", with an effective date of 7/08, indicated "...Cook(s) are responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination...." A current facility policy "Proper Hand Washing Practice", dated 8/20/12, indicated "...Hand washing is the single most effective thing food service workers can do to keep the food they serve safe...Each thing we		**present or near the steam table.**The residents had the potential to be affected by this deficient practice with no adverse outcomes identified on 10/31/12 by the Food Service Director.	

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	touch...is a potential source of contamination...." 3.1-21(i)(3)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and interview, the facility staff failed to carry clean	F0441	F 441 SS=E**A. How will the facility identify other residents**	11/16/2012

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	linen away from their clothing and failed to transport clean linen through the hallway to prevent potential contamination, potentially affecting 23 residents residing on the 300 hall of 90 residents in the facility. Findings include: 1. During an observation of the 300 Hall on 10/30/12 at 8:45 a.m., CNA #4 was observed carrying clean linen and bed blankets up against her clothing and into room 307. She was then observed to make the bed for room 307 A with the same linen. 2. During an observation of the 300 Hall on 10/31/12 at 8:55 a.m., CNA #5 was observed carrying clean linen and bed blankets up again her clothing and into room 311. At 9:00 a.m., she was observed to carry additional linen up against her clothing into the same resident's room. 3. During an observation of the 300 Hall on 10/31/12 at 2:03 p.m., a cart of clean linen was observed next to North nursing station. with the side covering pushed up on top of the cart. The side with the clean linen was exposed to the hallway. Three bed blankets were observed resting on the		**having the potential to be affected by the same deficient practice? a. Residents' who reside at the facility had the potential to be affected by the identified practice with no adverse outcomes.B. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?b. Certified Nursing Assistants #4, #5, and #6 were re-educated by the Director of Nursing on 10/31/12 on proper technique in regards to delivery of clean linens to the residents. The Assistant Director of Nursing, Unit Managers, and designee conducted re-education for the nursing staff on proper clean linen delivery to the residents by 11/15/12.C. What Measures will be put into place or what systemic changes you will make to assure the deficient practice does not recur? c. The Assistant Director of Nursing, Unit Managers, and designee will conduct an audit of clean linen delivery to the residents 3 times a week to ensure compliance with infection control policy.D. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? d. Infection control rounds will be conducted by the ADNS three**	

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	top of the cart. 4. During an observation of the 300 Hall on 10/31/12 at 3:34 p.m., CNA #6 was observed to push the same cart of clean linen through the 300 Hall delivering clean linen to resident rooms. The side covering remained pushed up on top of the cart and the three bed blankets remained un-covered on the top. The Director of Nursing was interviewed on 11/2/12 at 8:45 a.m. During the interview she indicated clean linen should be covered when transported through the hallways and staff should not hold clean linen up against their clothing. A facility policy concerning clean linen was requested during the interview. The Director of Nursing was interviewed on 11/2/12 at 10:20 a.m. During the interview she indicated the facility did not have a policy concerning the handling of clean linen. 3.1-19(g)		**times weekly times 4 weeks, weekly times 8 weeks, and monthly times 3 months to ensure that infection control practices are being followed in regards to proper handling of clean linens and distribution of linens to the resident's residing at the facility. Audits will be reviewed at monthly Performance Improvement Committee meetings for any further recommendations.**The **Director of Nursing/ ADNS/Designee will review the audits at the next monthly Performance Committee Meeting for any further recommendations. Audits will be ongoing to ensure compliance.of proper linen handling related to infection control.**	